Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HUNTSVILLE MEMORIAL HOSPITAL
1201 LAKE WOODLANDS DR #2024
THE WOODLANDS TX 77380

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-13-1113-01

MFDR Date Received
JANUARY 7, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We would contend that these denied charges qualify for an exemption under TEX. Lab. Code §408.0272(b)(1)(B) inasmuch as the attached bill was mistakenly submitted to the Claimant's health insurer during the 95 day window prescribed by 28 TEX. ADMIN. CODE For these causes, the Requestor asks that Medical Fee Dispute Resolution issue a Findings and Decision that HUNTSVILLE MEMORIAL HOSPITAL is entitled to reimbursement for services discussed herein, as well as all fees, interest and any other relief to which HUNTSVILLE MEMORIAL HOSPITAL may be justly entitled.."

Amount in Dispute: $170.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a review of the medical billing received from Huntsville Memorial Hospital, which determined that out of good faith the Office will allow reimbursement for billed CPT code 97001, however in review of CPT code 97110 will be denied as this service was performed more than 14 days post injury and prior authorization was not obtained. The Office has requested an immediate re-audit to allow reimbursement pursuant to the Division rules and payment policies to include interest where applicable."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2012	CPT Code 97110-GP CPT Code 97001-GP	$170.48	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 197 – Payment denied/reduced for absence of precertification/preauthorization.
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - W7 – Payment of interest/penalty to provider.
   - 193 – Original payment decision is being maintained. Upon reviewit [sic] was determined that this claim was processed properly.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Was preauthorization obtained?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.027 or §408.0272 should be applied..."

   Review of the documentation submitted by the respondent finds that they have re-audited the disputed services and issued payment for CPT Code 97001-GP under warrant number 128430835 in the amount of $113.58, plus interest of $1.94. The respondent has submitted an EOB and payment screen to support the payment was issued. Therefore, the timely filing denial is not supported.
2. The respondent issued an EOB after the re-audit denying CPT Code 97110-GP denying for absence of preauthorization. In accordance with 28 Texas Administrative Code 134.600 (p) Non-emergency health care requiring preauthorization includes: (5)physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (C)except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i)the date of injury, or (ii)a surgical intervention previously preauthorized by the carrier. Review of the documentation submitted by the requestor finds no preauthorization approval for the date of service in dispute. Therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.